Missouri Department of
SOCIAL SERVICES
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Executive Order 98-12
Implementation Report
For Fiscal Year 2010

MISSOURI DEPARTMENT OF
MENTAL
HEALTH

Executive Summary

- Executive Order 98-12 requires the Department of Social Services (DSS) and the Department of Mental Health (DMH) to report to the Governor on their collaboration on behavioral health matters, including activities related to managed care.

- DSS and DMH enjoy a positive working relationship and continue to work collaboratively on a number of projects to improve behavioral health services for Missourians. This positive working relationship is making a difference to the people the departments mutually serve.

- For managed care behavioral health, outcomes have generally improved from the inception of the collaboration.

- Variations in inpatient admissions have been experienced during the course of our collaboration. Data does not suggest a definitive cause, but the increase in admissions in the last year continues a negative trend. Inpatient days have similarly varied over time and increased in the past year.

- Managed care behavioral health readmission rates increased in the most recent year. This reverses the prior year positive trend.

Managed Care Indicators	**Movement Since EO 98-12** (Change 1999 to 2009 unless noted)	**Movement from Prior Year** (Change 2008 to 2009)
Mental Health Penetration Rates	●	●
➢ Ages 0-12 Years	●	●
➢ Ages 13-17 Years	●	●
➢ Ages 18-64 Years	●	●
Mental Health Inpatient Admissions Per 1,000	●	●
Mental Health Inpatient Days Per 1,000	●	●
Mental Health Outpatient Visits Per 1,000	●	●
Mental Health Ambulatory 7-Day Follow Up After Discharge	●	●
Mental Health Ambulatory 30-Day Follow Up After Discharge	●	●
Mental Health Inpatient Readmission Rate	● (Note: 2004 to 2008)	●
● Positive ● Unchanged ● Negative		

- Case management is a tool targeted at people in the fee for service population with schizophrenia and chronic diseases. It is pursued for high-risk participants who are likely to experience complications requiring additional services in the short term. Case management has substantially increased the number of participants linked to a medical home and a behavioral health home. Initial results show a decrease in hospital emergency room usage and improved adherence to treatment plans in general.

- The Behavioral Pharmacy Management (BPM) physician-oriented intervention is also used to manage behavioral health outcomes in the fee for service population. The table *(below)* shows both BPM participants and the comparison group had improved results when looking at six months prior to six months post control period. BPM participants were 7.3% less likely to be admitted to the hospital, had 0.15 fewer average hospital admissions, had 1,813 fewer hospital days for all cases, and had on average $1,238 less non-pharmacy medical costs when comparing their pre- and post-exposure to the program. While indicators did improve for the comparison group, changes were far less substantial.

Fee for Service Indicators (Based on Behavioral Pharmacy Management Participation)	**Behavioral Pharmacy Management Participants**	**Comparison Group**
Admitted to a Hospital	●	●
Mean Hospital Admissions	●	●
Total Hospital Days for All Cases	●	●
Total Hospital Days for All Cases	●	●
● Positive ● Unchanged ● Negative		

- Other important collaborative efforts between the departments include:

  - Non-Pharmaceutical Mental Health Services Prior Authorization Advisory Committee – Reviews and makes recommendations regarding the prior authorization process to the MO HealthNet Division (MHD) for non-pharmaceutical behavioral health services.

  - Clinical Consultation – As requested by MHD, DMH provides utilization reviews for the medical necessity of hospital admissions, appropriate length of stay and quality of treatment.

  - Mental Health and Juvenile Policy Group – Addresses the needs of youth involved in the juvenile justice system by improving utilization and quality of behavioral health assessments.

- Substance Abuse Treatment Referral Protocol for Pregnant Women Participating in MO HealthNet – Continue to utilize a protocol to facilitate referral of pregnant women in managed care in need of substance abuse treatment to the Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) program.

- System of Care Public Policy Activities – As mandated by Senate Bill 1003, the Children's Mental Health Reform Act, DMH is charged in partnership with other child care agencies and community stakeholders to draft a plan to establish a Comprehensive Children's Mental Health System. Significant components of the plan include diverting or transferring children from state custody, financing of community-based services, improving the assessment process of youth, establishing screening protocols and developing consistent standards of care.

- DMH and MHD Prescribing Practices Project – To improve patient outcomes by improving psychiatric prescribing practices, improving continuity of care across multiple prescribers, and improving patient adherence to medication treatments for MO HealthNet participants.

Introduction

Executive Order 98-12 was signed on August 12, 1998. This order requires the Department of Social Services (DSS) and the Department of Mental Health (DMH) to collaborate on behavioral health matters, including activities related to managed care. An annual report is submitted to the Governor's Office.

In the ensuing years the Department of Social Services, particularly the MO HealthNet Division (MHD), and the Department of Mental Health have established a strong and consistent collaborative working relationship that is focused on quality and accountability.

Executive Order 98-12 orders the Departments of Social Services and Mental Health to:

- Collaborate in developing, implementing, and maintaining a structure of managed care that increases the quality, access, availability, cost efficiency, and consumer satisfaction of managed care behavioral health services;

- Jointly address current concerns about the management of behavioral health care in the managed care program by sharing the expertise and knowledge of each department in their respective fields;

- Determine the managed care populations at risk, identify behavioral health needs of those individuals, and secure the most appropriate behavioral health treatment under the terms of managed care contracts;

- Develop strategies to build behavioral health systems capacity in underserved areas.

In addition, Executive Order 98-12 requires the Departments of Social Services and Mental Health to jointly:

- Analyze covered services;

- Establish reviews of health-related consumer grievances and provider appeals under the terms of managed care contracts;

- Establish behavioral health sentinel indicators;

- Identify required data, participate in data analysis and establish outcomes based on data analysis;

- Design and implement the quality assurance process for behavioral health; and,

- Participate in targeted reviews as necessary.

Executive Order 98-12 also requires the Departments of Social Services and Mental Health to collaborate to:

- Develop and evaluate Requests for Proposals;

- Participate in contract compliance reviews and readiness reviews of behavioral health organizations and managed care organizations; and

- Develop strong, clear, mandatory language regarding client rights in the client handbook.

The following summary lists activities and accomplishments in the designated areas, as well as references to additional collaborative activities. All of the above-designated areas are referenced, with the single exception of the final item. Mandatory client rights language has been addressed previously and has not had additional activity during the past year.

Executive Order 98-12 Collaboration

Managed Care Quality Assessment and Improvement Advisory Group. The MHD utilizes the Managed Care Quality Assessment and Improvement Advisory Group to work with stakeholders to improve services.

The Quality Assessment and Improvement Advisory Group include representatives from the Department of Mental Health. A DMH representative chairs the Quality Assessment and Improvement Behavioral Health Task Force. The MHD uses the Behavioral Health Task Force to address important issues of quality.

Establishment of Comparable Quality Indicators for Managed Care Health Plans[1]. Managed Care health plans self report a variety of indicators for behavioral health services. Indicators include overall penetration, penetration by age group, inpatient days per 1,000 members, residential days per 1,000 members, inpatient admissions per 1,000 members, inpatient substance abuse days per 1,000 members, inpatient substance abuse admission per 1,000 members, outpatient visits per 1,000 members, alternative services per 1,000 members, intensive outpatient visits per 1,000 members, ambulatory follow up within thirty days of inpatient discharge, and ambulatory follow up within seven days of inpatient

[1] Indicators are commonly defined and based on HEDIS (Health Employer Data Information Set) definitions.

discharge. Indicators are analyzed to monitor overall system operation and to determine trends. Review of recent data reported by health plans has indicated several trends in MO HealthNet managed care behavioral health, such as:

- The penetration rate has continued to show a consistent annual increase, with an overall 65.0% increase among the 0-12 year age category, a 102.8% increase among the 13-17 year age category, and a 70.3% increase among the 18-64 year old category, from 1999 to 2009. (This is a positive trend.)

- Managed care inpatient admissions per 1,000 increased by 32.5% between 2001 and 2009. (This is a negative trend.)

- Inpatient days per 1,000 increased by 20.9% from 2008 to 2009 for an overall increase of 52.7% since 1999. (This is a negative trend). It should be noted that analysis shows the average length of stay also increased during 2009. This means that the increase in inpatient days is not simply due to the increased number of inpatient admissions but the combination of more admissions and longer stays per admission. This has translated into a fairly dramatic increase in inpatient days per member month during 2009.

- Outpatient visits per 1,000 increased by 136.2%between 1999 and 2009, with a 12.6% increase between 2007 and 2008 and then another 13.5% increase during 2009. (This is a positive trend.)

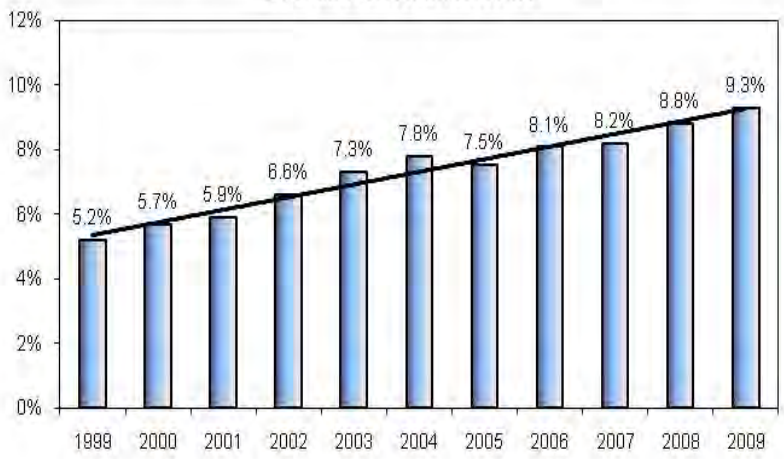
- The ambulatory follow up after discharge 7-day indicator in 2009 was 44.7% as compared to 47.0% in 2008. This puts Missouri ahead of the national rate of 42.6% for the second year but below the Missouri rate of 47.0% for 2008. (This is a negative trend for 2009 but a positive long term trend.)

- Since 2005, Missouri's rate of ambulatory follow up within 30-days following discharge has outperformed the national average and in 2008 did so by the widest margin seen over the course of this collaboration. In 2009 the Missouri rate decreased somewhat but at 68% remained well ahead of the national rate of 61.7%. (This is a negative trend for 2009 but a positive long term trend.)

- Behavioral health inpatient readmissions increased between 2004 and 2009. This negative overall trend reversed in 2008. However, the 2009 rate is 2.5% higher than in 2008 and18.6% higher than the benchmark 2004 rate. (This is a negative trend.)

Managed Care Behavioral Health Penetration[2]. The eleven-year trend in overall access to behavioral health services *(Figure 1)* indicates a fairly consistent annual increase. There has been a 79% improvement in the overall penetration rate between 1999 and 2009, including 23% improvement since 2005. Health plans continue to identify methods aimed at increasing member penetration (i.e., use of member educational and clinical case management activity).

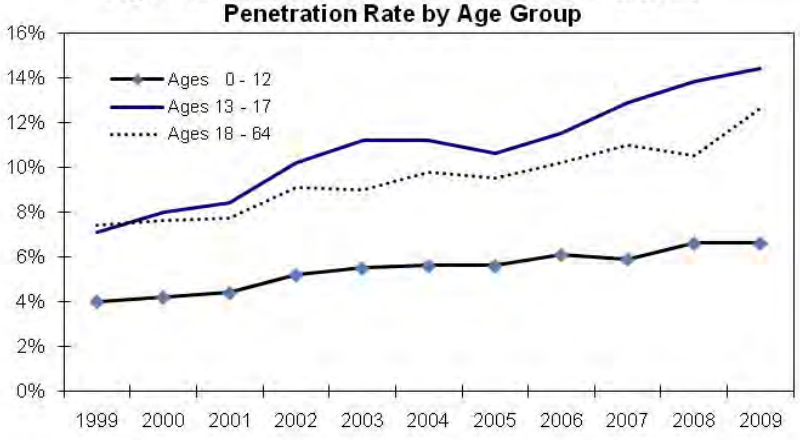
Figure 1. Managed Care Behavioral Health Services Overall Penetration Rate



Positive Trend

A drill down into the overall penetration rate above was performed to assess if similar trends were present for different age groups, with a particular focus on child health access *(Figure 2)*. Over the past eleven years, penetration in behavioral health services has seen a 65.0% increase among the 0-12 year age category and a 102.8% increase among the 13-17 year age category. These increases can be compared to the 70.3% increase in penetration rate for the 18-64 year old age group or the 79% increase across all age groups. Clearly, there has been an increasing penetration rate among both children and youth that compares well with the increase in the adult rate. Except for 1999, the strongest age specific penetration rate has consistently been seen in the 13-17 year age category.

Figure 2. Managed Care Behavioral Health Services Penetration Rate by Age Group



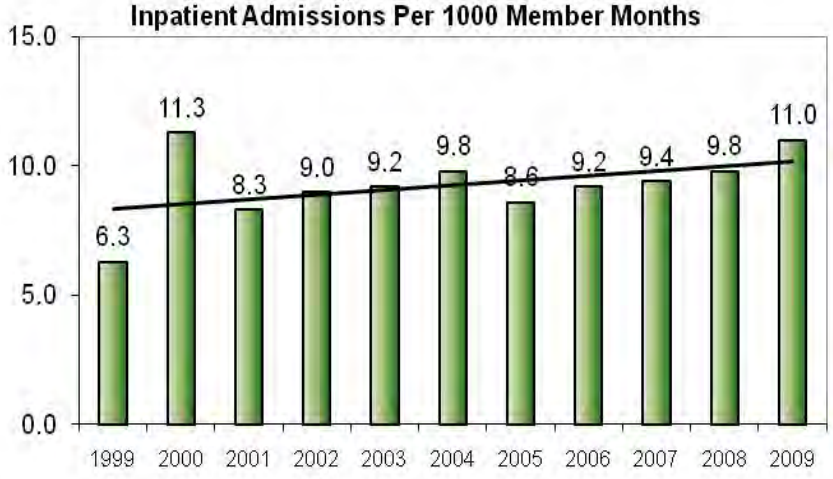
Positive Trend

Source for Figures 1 and 2: Managed Care Health Plan Behavioral Health Utilization Data

[2] Penetration is a measure of the percentage of health plan members accessing behavioral health services through Managed Care.

Managed Care Behavioral Health Inpatient Admissions. Behavioral health admissions per 1,000 member months (*Figure 3)* increased 12.2% in 2009 compared to the prior year. Admissions increased 32.5% between 2001 and 2009. There has been some annual variation from that overall trend, but the past 5 years have shown a consistently increasing rate of behavioral health inpatient admissions for Managed Care members. This is generally considered a negative trend as it represents a trend towards increased usage of more restrictive and more expensive health care settings.

Figure 3. Managed Care Behavioral Health Inpatient Admissions Per 1000 Member Months



Negative Trend

Managed Care Inpatient and Outpatient Behavioral Health Services. Behavioral health inpatient days per 1,000 member months *(Figure 4)* increased during 2009 by 20.9% from the prior reporting year -- there was a more than eight day increase in the average rate of behavioral health inpatient days per 1,000 member months. It should be noted that analysis shows the average length of stay also increased during 2009. This means that the increase in inpatient days is not simply due to the increased number of inpatient admissions but the combination of more admissions and longer stays per admission. This has translated into a fairly dramatic increase in inpatient days per member month during 2009.

Figure 4. Managed Care Behavioral Health Inpatient Days Per 1000 Member Months

Negative Trend

Source for Figures 3 and 4: Managed Care Health Plan Behavioral Health Utilization Data

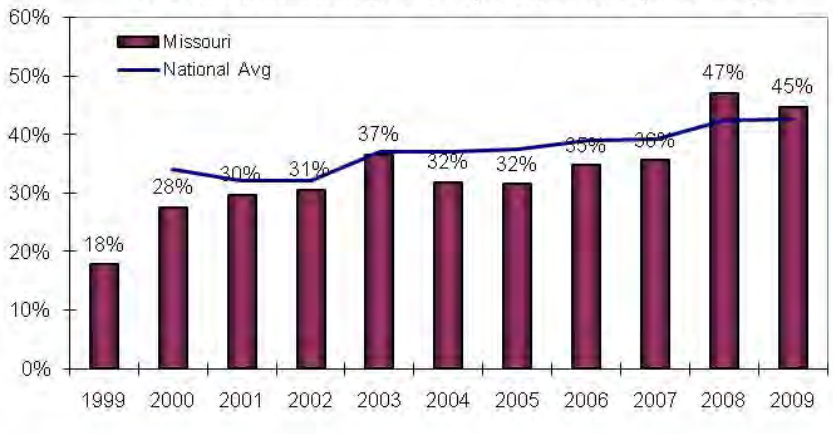
Behavioral health outpatient visits per 1,000 member months *(Figure 5)* increased 136.2% between 1999 and 2009 with a 12.6% increase between 2007 and 2008 and another 13.5% increase during 2009. This trend has been particularly consistent for the most recent 5 years and an upward trend in outpatient visits is a desirable trend. Multiple factors could be contributing to the increase in utilization including increased advocating for conjoint therapy with both a therapist and a psychiatrist when a member calls in to obtain an authorization solely for a psychiatrist. There has been a continued focus on improving ambulatory follow-up rates, which can increase authorization for outpatient care. An increase in authorization of in-home therapy sessions increased the rates of members keeping scheduled appointments, and in turn, increasing outpatient utilization.

Figure 5. Managed Care Behavioral Health Outpatient Visits Per 1000 Member Months

Positive Trend

Managed Care Ambulatory Follow Up. Ambulatory follow up after a behavioral health discharge *(Figures 6 and 7)* continues to be an important indicator of quality at the national level. Ambulatory follow-up rates are reported by health plans across the country on an annual basis and are reported by the National Committee for Quality Assurance[3] (NCQA) as an effectiveness of care measure. The national mean rates are used as a comparison to the managed care health plan performance (national data is available going back to 2000). In 2009 the 7-day rate for Missouri was 44.7% -- ahead of the national rate of 42.6% for the second year but below the Missouri rate of 47.0% for 2008.

Figure 6. Managed Care Behavioral Health Percent with Ambulatory Follow Up 7 Days After Inpt. Discharge



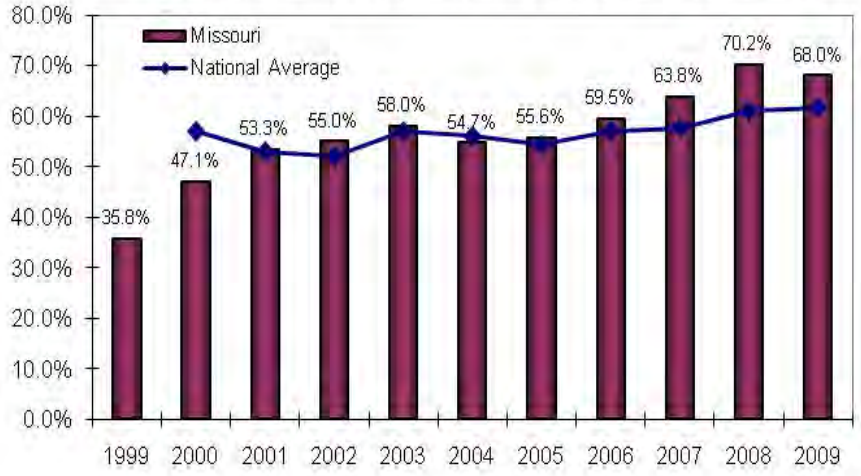
Negative Trend in 2009 Positive Long Term Trend

Source for Figures 5 and 6: Managed Care Health Plan Behavioral Health Utilization Data

[3] National Committee for Quality Assurance is an independent, 501(c) (3) non-profit organization whose mission is to improve health care quality everywhere.

Since 2005, Missouri's rate of ambulatory follow up within 30 days *(Figure 7)* has outperformed the national average, and in 2008 did so by the widest margin seen over the course of this collaboration. In 2009 the Missouri rate dropped somewhat but at 68.0% remained well ahead of the national rate of 61.7%.

Figure 7. Managed Care Behavioral Health
Percent with Ambulatory Follow Up 30-Days After Inpt. Discharge

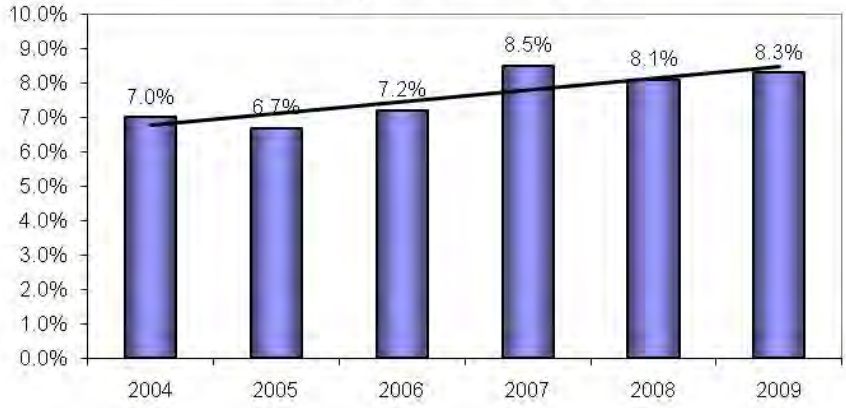


Negative Trend in 2009
Positive Long Term Trend

Managed Care Inpatient Readmission Rate.

Behavioral health inpatient readmissions *(Figure 8)* increased between 2004 and 2009. This negative overall trend reversed in 2008. However, the 2009 rate is 2.5% higher than in 2008 and 18.6% higher than the benchmark 2004 rate. The Managed Care health plans' efforts to address member readmission must thereby continue and include, but not be limited to:

Figure 8. Managed Care Behavioral Health
Inpatient Readmission Rate



Negative Trend

Source for Figures 7 and 8: Managed Care Health Plan Behavioral Health Utilization Data

- Working with participants, facilities, and outpatient providers to increase member adherence with follow-up appointments and expanding current hospital to home programs;
- Referring participants with co-morbid and high psychiatric acuity to intensive case/disease management programs; and
- Including physical and behavioral health professionals in management of the Managed Care participants.

Managed Care Performance Measurement Activities for 2010. The MO HealthNet Managed Care Behavioral Health Task Force has developed specifications for a new collection of performance metrics. The initial collection and review of baseline data based upon those specifications is ongoing. The new measurement definitions rely more heavily on existing national benchmark standards, particularly

National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set Health (HEDIS) specifications, which will enable more extensive benchmarking of Missouri's performance to those national standards and result in more reliability in the data. These measures overlap with the existing metrics used in this annual report.

Inherent in the development of the new performance metrics is they will not (initially) provide the perspective that can be derived from the eleven years of trended data available from the existing metrics. For this reason, a significant activity for the coming year will be the comparison and contrast between the old and new measures, to identify existing measures that will need to be utilized going forward for continuity of measurement. The end result of this development process will be a more robust set of behavioral health performance metrics, combining the best of the existing long term trend measures with the new metrics.

The measures under development will be collected at the health plan, regional and statewide level and currently include:

- Number of providers (child psychiatry, adult psychiatry, psychologist, other BH) per 1,000 members,
- Number full-time equivalent (FTE) (child psychiatry, adult psychiatry, psychologist, other BH) per 1,000 members,
- Percent of open psychiatrist panels,
- Percent of psychiatry practices with emergency appointment availability within 6 hours (NCQA Standard),
- Percent of psychiatry practices with urgent appointment availability within 48 hours (NCQA Standard),
- Percent of psychiatry practices with routine appointment availability within 10 days (by age group) (NCQA Standard),
- Penetration rates (using HEDIS service category definitions) by age group,
- Outpatient visits per 1,000 members,
- ER Visits per 1,000 members,
- Outpatient + ER Visits per 1,000 members (HEDIS definitions),
- Percent of members with access to practitioners (by category) within distance specified in the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) Network Adequacy Standards (20 CSR 400-7.095),
- Percent of members with access to service type (by category) within distance specified in the DIFP Network Adequacy Standards,
- Inpatient Mental Health Days per 1,000 members (HEDIS definition, numerator only),
- Inpatient Substance Abuse Days per 1,000 members (HEDIS definition, numerator only),
- Inpatient Denials (NCQA definitions) per 1,000 members,
- Percent of appeals of inpatient denials overturned and upheld,
- Inpatient readmission rates for members in case management,

- Case Management Patient Satisfaction Rates, and
- Ambulatory Follow-up after Inpatient for Mental Health (7 and 30 day) (HEDIS definitions).

Additional Interdepartmental Collaboration

Care Management for Persons with Schizophrenia and Chronic Diseases. On a quarterly basis, the DMH analyzes the MHD fee-for-service claims to identify MO HealthNet fee-for-service (FFS) participants who are at high risk and are likely to experience complications requiring additional services in the coming six months. Health care providers are sent summary reports of the identified participants' medical conditions and health care service history along with recommendations for improving care. Behavioral health case managers assist participants in accessing necessary medical care. This project has substantially increased the number of participants linked to both a medical home and a behavioral health home utilized for the goal of meeting their total health care needs. Initial results show a decrease of hospital emergency room usage and improved adherence to treatment care plans in general.

The study found statistically significant differences between the pre- and post-exposure periods for all of the primary outcomes of interest – rates of hospitalizations, mean number of admissions to a hospital, total patient hospital days, and total non-pharmacy charges.

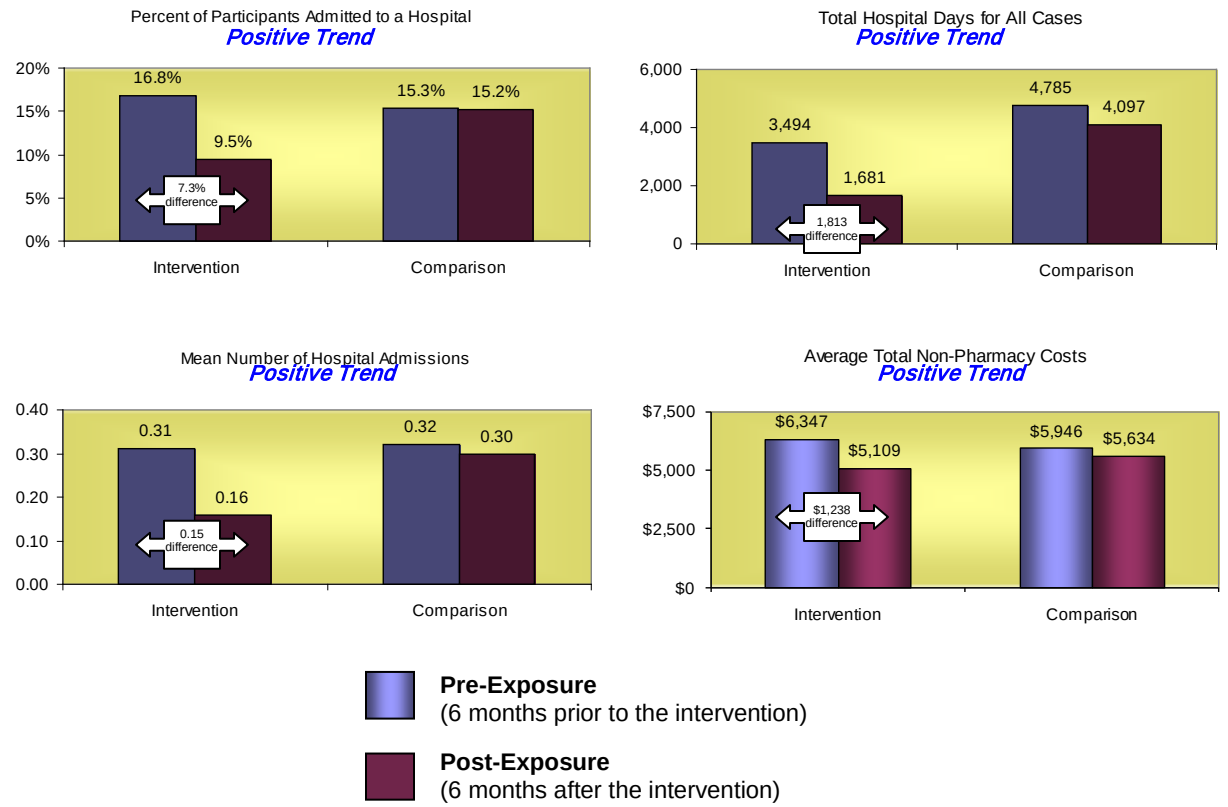
The Behavioral Pharmacy Management (BPM) physician-oriented intervention is associated with a decrease in hospitalizations as evidenced by reductions in the overall rates of admission, the mean number of admissions per patient, and the total patient days. In addition, there is an overall reduction in the total average medical services cost of care for MO HealthNet FFS participants.

There were 7.3% less FFS participants admitted to the hospital, a decrease of 0.15 mean number of hospital admissions, a decrease of 1,813 total hospital days for all cases, and $1,238 decline in average total non-pharmacy costs *(Figure 9)*.

There were no statistically significant changes in any of the primary outcomes within the comparison group between the two time periods. This indicates that there were no time influences on admissions or payments during the time period of analysis.

The relatively low cost intervention (BPM) helps the state to identify the MO HealthNet FFS participants who are of greatest concern from a financial perspective.

Figure 9. Behavioral Pharmacy Management



Non-Pharmaceutical Mental Health Services Prior Authorization Advisory Committee. The DMH actively participates in the Non-Pharmaceutical Mental Health Services Prior Authorization Advisory Committee, which reviews and makes recommendations regarding the prior authorization process to MHD. Two DMH Clinical Directors and practicing clinicians participate in the committee as behavioral health experts representing multiple disciplines. The DMH Clinical Directors actively participate in the development of practice guidelines and ongoing clinical consultation regarding the authorization of non-pharmaceutical behavioral health services.

Clinical Consultation. As requested by MHD, the DMH provides utilization review for the medical necessity of admission and appropriate length of stay, as well as quality of treatment for inpatient hospital stays.

The DMH Clinical Director regularly participates in and provides technical assistance in behavioral health areas to the following MHD committees:

- Drug Utilization Review Committee;
- Non-Pharmaceutical Mental Health Services Advisory Committee;
- Managed Care Quality Assessment and Improvement Advisory Group;
- APS HealthCare/Chronic Care Improvement Program Quality (through 7/31/10); and
- Improvement Advisory Committee

In addition, the DMH Clinical Director for Children, Youth and Families provides clinical consultation to the Department of Social Services, Children's Division on youth with severe behavioral health needs that require specialized, individualized care.

Mental Health and Juvenile Justice Policy Group. The Mental Health and Juvenile Justice Policy Group was formed in 2005 in response to a National Policy Academy on improving services for youth involved in the juvenile justice system. A state level team attended the National Policy Academy and established and expanded agency participation to address the needs of this population of youth, including youth who are delinquent and youth under the court's jurisdiction for abuse/neglect. Representatives from Department of Social Services, including Children's Division, Division of Youth Services, and MHD, serve on this state group. The team's initial priority was to improve utilization and quality of mental health assessments within the juvenile court and child welfare system. The Office of State Courts Administrator and DMH applied for and received a grant through the Office of Juvenile Justice and Delinquency Prevention to provide a field demonstration on improving the quality of mental health services to youth in the juvenile justice system. Guidelines for conducting evaluations for child welfare and juvenile justice were developed and sites were trained on these guidelines in the five selected grant sites. Sites also selected an evidence based practice to address the needs of the identified population. Two sites were trained on Trauma Focused Cognitive Behavior Therapy, one site on Dialectical Behavior Therapy, one site on Motivational Interviewing and Strengthening Families, and one site selected both prevention and intervention school strategies that targeted substance abuse.

The Mental Health and Juvenile Justice Policy Team are now focusing on youth with problem sexual behaviors. The Team has attempted to examine the prevalence of youth with these issues and how they are identified and treated in the system. There is not a consistent and effective mechanism to address the safety needs of this population. The team has developed a joint vision and guiding principles for working with this population and is now exploring different approaches and interventions.

Substance Abuse Treatment Referral Protocol for Pregnant Women under MO HealthNet Managed Care. During 2009, the DMH Division of Alcohol and Drug Abuse (ADA) and MHD continued utilization of a protocol to facilitate referrals of pregnant women in managed care in need of substance abuse treatment to Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) Program, particularly to the specialized Women and Children CSTARs. The protocol guides collaboration between the primary care providers, CSTAR providers, Managed Care health plan case managers, and pregnant women to ensure that pregnant women in need of substance abuse treatment receive timely treatment and appropriate medical services.

The protocol facilitates communication between stakeholders by providing geographic locations and contact information for CSTAR treatment programs and Managed Care health plans. A multi-party consent to release information form is included in the protocol to document the pregnant women's informed consent for appropriate sharing of information between referring and treating entities. CSTAR providers are required to communicate sentinel treatment events to primary care providers and health plan case managers. CSTAR providers are also required to involve primary care providers and health plan case managers in the pregnant women's continuing care plans. The ADA Clinical Utilization Review Unit monitors referral to CSTAR treatment programs through the protocol and ensure appropriate communication between the primary care providers and health plan case managers. The ADA Clinical Utilization Review Unit submits quarterly reports to the MHD that track referrals and follow-up communication activities and issues for review.

ADA CSTAR Pregnant Consumer Admissions

January 1, 2009 – December 31, 2009

Agency	Blue Advantage Plus	Children's Mercy FHP	Harmony	HealthCare USA	Molina HealthCare of MO	MO Care	Total	%
Alternative Opportunities	0	0	0	1	1	0	2	1
BASIC	0	0	0	2	1	0	3	1
Bridgeway	0	0	1	15	10	0	26	13
Center for Life Solutions	1	0	0	12	1	1	15	8
Comprehensive Mental Health Services	5	6	0	3	2	0	16	8
Family Counseling Center of Missouri	0	1	0	6	0	7	14	7
Hannibal Council on ADA	0	0	0	2	3	2	7	4
New Beginnings	0	0	0	5	1	0	6	3
Pathways	0	0	0	1	0	1	2	1

Preferred Family Healthcare	0	0	0	8	2	4	14	7
Queen of Peace	0	0	6	25	15	0	46	23
ReDiscover	7	3	0	4	5	0	19	10
Samuel U Rogers Health Center (Opioid)	0	0	0	1	1	0	2	1
Southeast MO Behavioral Health (SEMO)	0	0	1	4	1	1	7	4
Tri-County Mental Health Services	0	1	0	0	0	0	1	0
Westend Clinic	0	0	3	10	4	0	17	9
Totals	13	11	11	99	47	16	197	100%
Percentage	7%	6%	6%	50%	23%	8%	100%	

Summary of 2009

In 2009, the ADA made concerted efforts to educate contracted treatment providers regarding the goals, purposes and procedures involved in the pregnancy monitoring protocol. Communication and care coordination continue to be focus areas for improvement. The Division of ADA recommends continued efforts to actively engage treatment providers, Managed Care health plans, and Managed Behavioral Healthcare Organizations. The goals of these efforts will be to reduce any duplication of services and enhance the quality of coordinated care delivered to each consumer. Longer-term goals of the project include expanding the communication protocol to include all ADA-contracted substance abuse treatment providers.

System of Care Public Policy Activities. The Children's Division continues to partner with the DMH on a variety of system of care related activities. Senate Bill 1003, the *Children's Mental Health Reform Act*, was passed by the General Assembly and signed by the Governor during 2004. Among its provisions was the charge that the DMH, in partnership with other child serving state agencies and community stakeholders, craft a plan to establish a Comprehensive Children's Mental Health System for Missouri. This plan was submitted to the Governor and General Assembly in December 2004.

A. Comprehensive System Management Team.

The Comprehensive System Management Team (CSMT) was formed in support of Senate Bill 1003 and provides state level interagency implementation leadership on policies, programs and practice. Representatives from all child-serving agencies including the three Divisions within the Department of Mental Health, the Children's Division, the Division of Youth Services, the Department of Elementary and Secondary Education, MHD, the Office of State Courts Administrators, local courts, the Department of Public Safety, four federally funded System of Care (SOC) sites along, with parents

and advocacy groups serve on the CSMT. The goal of the CSMT is to implement the Comprehensive Children's Mental Health Plan. Specific accomplishments through the end of FY09 were outlined in the *2009 Status of Children's Mental Health in Missouri: Comprehensive Children's Mental Health System.*

The CSMT process to accomplish tasks has always been by utilization of various standing and/or adhoc committees. This summer the CSMT approved a plan to integrate all committees into one State SOC Working Group. It is anticipated that this change will provide an avenue for increased involvement from local teams in addition to streamlining the push forward to implement reforms guided by the CSMT.

Since 2009 the CSMT has focused on two primary goals. First, to institutionalize system of care values into all child-serving state agencies including request for proposals, staff orientations, staff training, contracts, job descriptions, etc. And the second goal is to expand local system of care teams statewide. Two new teams (Clay/Platte and Ray counties) have now been sanctioned by the CSMT.

The system of care website continues to be updated with the goal of being easier to navigate and use. A calendar has been added along with an interactive blog. Local system of care teams and other organizations are encouraged to develop WebPages and post system of care-related activities on the website.

Quality Service Reviews (QSR) continues to be conducted at SOC sites with data to be used for planning, policy, and funding recommendations. The QSR process has been manualized at all levels.

The 2009 Annual Report on the *Status of Children's Mental Health in Missouri: Comprehensive Children's Mental Health System* was forwarded to the Children's Service Commission. An annual update is now in process and will be forwarded to the Commission in December.

B. Stakeholders Advisory Group.

The Stakeholders Advisory Group (SAG) decided to prioritize the following four goals: 1) Education; 2) The growth of family participation; 3) Training for partners and providers; and 4) Monitoring of the QSR. The SAG continues to work on recruiting and retaining new membership. A specific product developed this year and endorsed by the CSMT was a position paper on reimbursing family members for their time spent on state and local policy committees.

C. REACCH.

The youth group REACCH (Responding through Empowerment and Action to Create Communities of Hope) continues to meet on a quarterly basis. The purpose of REACCH is to ensure "youth voice" in the state's mental health issues. This year REACCH has worked on recruitment and is also looking at how to sustain its activities after grant funding ends next year.

Reducing Number of Youth in State Custody Solely to Access Behavioral Health Services. This continues to take a two-prong approach. The Custody Diversion Protocol implemented statewide in December of 2004 and the Voluntary Placement Agreement in February of 2005, through a partnership between the DMH and the Children's Division, allow the state to divert children from state custody solely to access behavioral health services. Extensive training has occurred across the state since inception. Through June of 2010, 1,033 youth have been referred through the Custody Division Protocol, with 96% successfully diverted from state custody. Of the youth diverted 33% were maintained with services in their home and community, and another 11% were only out of home for a brief period of time (less than one month). The Transfer of Custody (Senate Bill 1003) initiated at approximately the same time allows the Family Support Team of children in Children's Division custody to review for appropriateness of transferring the child's legal custody back to their parents due to the absence of abuse/neglect or significant safety issues. Both the Diversion Protocol and Transfer Protocol are supported through interagency agreements related to funding of behavioral health services, with Children's Division providing support through the Voluntary Placement Agreement and funding following the child when transferred out of Children's Division custody.

Missouri Department of Mental Health and MO HealthNet Division Program Prescribing Practices Project. This project began in January 2003 through formal agreements between the DMH, MHD, and Comprehensive Neuroscience.

The goal of the project is to improve patient outcomes by improving psychiatric prescribing practices, improving continuity of care across multiple prescribers, and improving patient adherence to medication treatments for patients in the MO HealthNet program. Secondary goals include containing pharmacy costs and maintaining access to the open formulary of psychiatric medications.

The project's method and interventions are based on the following principles: (1) prescribing and pharmacy utilization management decisions should be based on data instead of anecdote;
(2) interventions should make use of existing data sets and support the current prescribers; and
(3) interventions should be respectful of physician/patient autonomy and minimize unintended consequences. The project assumes that prescribing consistent with nationally recognized best practice standards will lower overall health care costs and that prescribers will voluntarily adhere to national standards when they know what they are.

Evidence-based and expert consensus medication practice guidelines from the peer-reviewed literature are used to identify medication prescription patterns that are usually inconsistent with best practice.

Pharmacy claims from MHD are transmitted to Comprehensive Neuroscience for monthly analysis to identify prescribing patterns falling outside nationally recognized best practice guidelines. The DMH Medical Director and MHD Pharmacy Director determined areas of prescribing practice to focus educational alerts to outlier prescribers for quality improvement. The number of prescribers, both psychiatrist and primary care, who receive monthly mailings varies from 1,500 to over 3,000 a month. Prescribers receive a cover letter identifying areas of prescribing concern, patient specific information and educational monographs describing the relevant best practice guideline(s). In addition, the project alerts all Missouri physicians of patients who failed to refill their antipsychotic medications in a timely fashion or were prescribed multiple drugs of the same chemical class concurrently from different physicians. Prescribers also receive a report of all psychiatric medications their patients have received in the previous 90 days including date, dosage, prescriber (including those other than themselves) and dispensing pharmacy. Prescribers are offered telephone consultation by psychiatrists with specific psychopharmacology expertise.

Prescription of psychiatric medications for the treatment of mental illness is the most common and most effective treatment modality currently available. There are very few innovative programs focused on improving the quality and outcomes of psychiatric prescribing and none that have been acknowledged with a Gold award from the Utilization Review Accreditation Commission (URAC). The partnership is led by a psychiatrist and has successfully improved the quality of psychiatric prescribing by both psychiatrists and primary care prescribers and has demonstrated improved clinical outcomes and cost savings. The partnership is widely recognized as a national innovation and has been rapidly replicated throughout the nation. It has continuously improved its method and continues to innovate new approaches.